Non-Preferred Authorization Request

Patient name:_____Medicaid or SS#_____
Physician Name:_____Contact person:_____
Phone#:_____Ext. and opt._____Fax#_____
Pharmacy_____Pharmacy Phone#:_____Pharmacy Fax #_____

All information to be legible, complete and correct or form will be returned

_____

FAX INFORMATION TO: 801-536-0477

CRITERIA:

Requested Non-preferred drug:

Drug Name_____Daily Dose:_____Monthly Quantity: _____

Circle and Explain in detail and save copy in the patient's chart for audit purposes to support **one of the following**:

- Explain in detail a trial and failure of at least one preferred agent in the class, including name of the preferred product(s) tried, length of therapy and reason for discontinuation.
- Explain in detail evidence of a potential drug interaction between current medication and the preferred product(s).
- Explain in detail evidence of a condition or contraindication that prevents the use of the preferred product(s).
- Explain objective clinical evidence that a patient is at high risk of adverse events due to a therapeutic interchange.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Prescriber Signature_____

AUTHORIZATION: 1 year

RE-AUTHORIZATION:

Telephone call from physician's office or pharmacy.

5/14/2009